

Chapter 28-000 PRESUMPTIVE ELIGIBILITY

28-001 Presumptive Eligibility for Pregnant Women: Under Section 1920 of the Social Security Act, the Nebraska Medical Assistance Program covers ambulatory prenatal care provided by an enrolled NMAP provider to a pregnant woman during a presumptive eligibility period determined by a qualified provider. A pregnant woman is eligible for only one presumptive eligibility period per pregnancy.

Ambulatory prenatal care is defined as ambulatory services related to the pregnancy excluding inpatient hospital services, nursing home services, labor and delivery services, and services furnished to deliver or remove an embryo/fetus from the mother or services following such a procedure.

28-001.01 Definition of a Qualified Provider: Only a qualified provider is allowed to make the presumptive eligibility determination. A qualified provider must meet the following four criteria:

1. Have a current provider agreement with NMAP;
2. Provide services of the type provided by one of the following:
 - a. An outpatient hospital;
 - b. A rural health clinic; or
 - c. A clinic under the direction of a physician, without regard to whether the clinic itself is administered by a physician;
3. Meet one of the following requirements:
 - a. Receive funds under one of the following:
 - (1) The Migrant Health Centers or Community Health Centers (Sections 329, 330, or 340, of the Public Health Service Act);
 - (2) The Maternal and Child Health Services Block Grant Program (Title V of the Social Security Act); or
 - (3) Title V of the Indian Health Care Improvement Act;
 - b. Participate in a program established under one of the following:
 - (1) The Special Supplemental Food Program for Women, Infants, and Children (Section 17 of the Child Nutrition Act of 1966); or
 - (2) The Commodity Supplemental Food Program (Section 4(a) of the Agriculture and Consumer Protection Act of 1973);
 - c. Participate in a State perinatal program; or
 - d. Is itself the Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (P.L. 93-638); and
4. Have been specifically designated in writing by the Medicaid Division as a qualified provider for the purposes of determining presumptive eligibility.

The provider shall immediately notify the Medicaid Division in writing should they no longer meet the required criteria to be a qualified provider. The provider shall discontinue making presumptive eligibility determinations when the requirements for being a qualified provider are no longer met.

28-001.02 Provider Approval: A provider who meets the requirements of 471 NAC 28-001.01 may request approval as a qualified provider for presumptive eligibility determinations from the Medicaid Division. The provider shall submit a written request for approval as a qualified provider to the Administrator of the Medicaid Division. The written request must identify the requirements of 471 NAC 28-001.01 the provider meets as well as how the provider will check active or pending Medicaid status for potential presumptively eligible pregnant women. The Medicaid Division shall coordinate with the Economic Assistance Division and the local Department of Health and Human Services (DHHS) office for the training of the qualified provider. The provider must be trained by the Medicaid and Economic Assistance Division staff, or staff approved by the Medicaid and Economic Assistant Division, before approval as a qualified provider is given. Final approval of the trained qualified provider is made in writing by the Medicaid Division. The designation of a qualified provider may be terminated by the Medicaid Division upon written 30-day notice to the qualified provider.

28-001.03 Presumptive Eligibility Determination: A pregnant woman may apply for presumptive eligibility for ambulatory prenatal services at a qualified provider's office. The provider shall make a presumptive eligibility determination of the woman's eligibility based only on income. For income levels, see 471-000-202. The provider does not investigate resources or other eligibility requirements. The DHHS worker shall determine eligibility for medical assistance within 45 days of the woman's application for medical assistance.

28-001.04 Responsibilities of the Qualified Provider: The qualified provider shall complete the following actions during the process of making a presumptive eligibility determination -

1. Check for any current or pending Medicaid eligibility prior to completing a presumptive eligibility determination;
2. Check for any past presumptive eligibility period during the client's current pregnancy;
3. Inform the woman at the time the determination is made -
 - a. The copy of the presumptive eligibility application is the client's proof of coverage;
 - b. She is required to follow through with the eligibility process;
 - c. Her presumptive eligibility ends when a final determination for continuous medical assistance is made by DHHS ; and
4. Forward a copy of the presumptive eligibility application to the local DHHS office within five working days after making a presumptive eligibility determination.
5. If the woman is not presumptively eligible, inform her in writing -
 - a. Of the reason for her ineligibility; and
 - b. That she may file an application for the Nebraska Medical Assistance Program (also known as medical assistance or Medicaid) at the local DHHS office.

28-001.05 Appeal Rights: The standard notice and appeal rights apply for a woman who has been denied continuous medical assistance (see 465 NAC 2-001). There are no appeal rights with regard to the denial of presumptive eligibility.

28-002 (Reserved)

28-003 Presumptive Eligibility for Women with Cancer: Under Section 1920B of the Social Security Act, the Nebraska Medical Assistance Program (NMAP) covers services provided by an enrolled NMAP provider to a woman during a presumptive eligibility period when the woman has been screened by the Every Woman Matters Program and found to have breast or cervical cancer. Presumptive eligibility must be determined by a qualified entity.

Beginning September 1, 2001, women determined presumptively eligible will be eligible for the full scope of services under the State Plan during the presumptive eligibility period. A woman may qualify for presumptive eligibility each time a qualified provider finds her to meet the presumptive eligibility requirements.

28-003.01 Definition of a Qualified Entity: Only a qualified entity is allowed to make the presumptive eligibility determination. A qualified provider must meet the following criteria:

1. Is eligible for payments under the Medicaid State Plan and provides items and services covered by the NMAP or is eligible for payments as an administrative contractor under the State Medicaid plan, and
2. Is determined to be capable for making presumptive eligibility determinations and has been specifically designated in writing by the Medicaid Division as a qualified entity for the purpose of determining presumptive eligibility in accordance with the requirements listed and any other limitations issued by the Center for Medicare and Medicaid Services (CMS).

The provider must immediately notify the Medicaid Division in writing should they no longer meet the required criteria to be a qualified provider. The provider shall discontinue making presumptive eligibility determinations when the requirements for being a qualified provider are no longer met.

28-003.02 Provider Approval: An entity who meets the requirements of 471 NAC 28-003.01 may request approval as a qualified entity for presumptive eligibility determinations from the Medicaid Division. The entity must submit a written request for approval as a qualified entity to the Administrator of the Medicaid Division. The written request must identify the requirements of 471 NAC 28-003.01 the provider meets as well as how the provider will check active or pending Medicaid status for potential presumptively eligible women with either breast or cervical cancer. The Medicaid Division shall coordinate with the Economic Assistance Division and the local Department of Health and Human Services (DHHS) office for the training of the qualified entity. The Medicaid Division makes final approval of the trained qualified entity in writing. The entity must be trained by the Medicaid and Economic Assistance Division staff, or staff approved by the Medicaid and Economic Assistance Division, before approval as a qualified entity is given. The Medicaid Division, upon written 30-day notice to the qualified provider, may terminate the designation of a qualified entity.

28-003.03 Presumptive Eligibility Determination: A woman in need of treatment for certain breast or cervical cancer conditions may apply for presumptive eligibility for Medicaid-covered services at a qualified provider's site. The qualified entity shall make a presumptive eligibility determination based only on the eligibility requirements in 469 NAC 9-000 which state that a woman must:

1. Be screened for breast and cervical cancer by Every Woman Matters;
2. Be found to need treatment for breast and/or cervical cancer, including a pre-cancerous condition or early stage cancer;
3. Be uninsured, not have creditable coverage or be covered by Medicaid;
4. Be a Nebraska Resident.

The qualified entity does not investigate resources or other eligibility requirements. The DHHS must determine eligibility for medical assistance within 45 days of the woman's application for medical assistance.

28-003.04 Responsibilities of the Qualified Entity: During the process of making a presumptive eligibility determination the qualified entity must:

1. Check for any current or pending Medicaid eligibility prior to completing a presumptive eligibility determination;
2. Inform the woman at the time the determination is made that:
 - a. The copy of the presumptive eligibility application is the client's proof of coverage;
 - b. She is required to follow through with the eligibility process by applying for Medicaid no later than the last day of the month following the month during which the presumptive eligibility determination is made.
 - c. The presumptive eligibility ends when a final determination is made by DHHS or if the woman does not apply for Medicaid, the last day of the month following the month during which the entity makes the presumptive eligibility determination.
3. Forward a copy of the presumptive eligibility application to the DHHS office within five working days after making a presumptive eligibility determination.
4. If the woman is not presumptively eligible, inform her (or the individual acting on her behalf) in writing:
 - a. Of the reason for ineligibility; and
 - b. That she may file an application for medical assistance at the local DHHS office.

28-003.05 Appeal Rights: The standard notice and appeal rights apply for a woman who has been denied continuous medical assistance. There are no appeal rights with regard to the denial of presumptive eligibility.